ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Companion Document and Transaction Specifications for the HIPAA 835 Claims Remittance Advice Transaction

Version 1.6
August 2007

Revision History

Date	Version	Description	Author
05/12/2003	1.0	Initial draft for posting to the AHCCCS Web Site	AHCCCS Information Services Division
07/18/2003	1.1	Draft document for posting to the AHCCCS Web Site for HIPAA Transaction and Code Set implementation	AHCCCS Information Services Division
09/09/2003	1.2	Draft with detail-level modifications for posting to the AHCCCS Web Site.	AHCCCS Information Services Division
12/05/2003	1.3	Draft for HIPAA Transaction and Code Set implementation	AHCCCS Information Services Division
03/04/2004	1.4	Final Companion Document for 835 Claims Remittance Advise Transaction implementation	AHCCCS Information Services Division
06/08/2004	1.5	Final Companion Document for 835 Claims Remittance Advise Transaction implementation	AHCCCS Information Services Division
08/20/2007	1.6	NPI Changes	AHCCCS Information Services Division

Change Summary

#	Location	Previously Stated	Revision
1	p.5, §2.1 Transaction Overview, Claim Remittance Advice Transaction subsection, 5th paragraph, 2nd sentence	Because payments are necessarily made from AHCCCS bank accounts, providers that treat patients with AHCCCS funding sources for which AHCCCS maintains separate accounts (currently Acute Services, Long Term Care, and KidsCare) receive a weekly 835 Transaction for each account from which they are due payment.	Because payments are made from AHCCCS bank accounts, providers that treat patients with AHCCCS funding sources for which AHCCCS maintains separate accounts (currently Acute Services, Long Term Care, and KidsCare) receive a weekly 835 Transaction for each account from which they are due payment.
2	p.6, §2.1 Transaction Overview, Claim Remittance Advice Transmission Schedules subsection,	A detailed mapping document shows the relationships between the PMMIS Claim Reason Codes that appear on the pre-HIPAA AHCCCS Remittance Advice and the Remark Codes on the 835 Transaction. The mapping document is available on the AHCCCS Web Site (http://www.azahcccs.gov). Click on Plans & Providers, then HIPAA, then TCS Documents, then AHCCCS HIPAA Transaction Work Papers, then 835 Remittance Advice Codes and Values Mapping.	<deleted>
3	p.7, §2.2 835 Claim Remittance Advice Transaction, Transaction subsection, 1st sentence	AHCCCS sends 835 Remittance Advice Transactions to electronic claim submitters on a weekly basis.	AHCCCS sends 835 Remittance Advice Transactions to its receivers on a weekly basis.
4	p.9, §3.2 File Naming Conventions, 835 Transaction Overview subsection	AZ-835-01-20031113-HHMMSS-020107.TXT 835 File AZ-835-02-20031113-HHMMSS-020107.TXT Supplemental File File Extension Provider ID Time Process date File Type Transaction Code State Code	AZ-835-01-20031113-054321-020107-1.TXT 835 File AZ-835-01-20031113-054321-020107-1.TXT Supplemental File File Extension Location Code Provider ID Time Payment date File Type Transaction Code State Code

#	Location	Previously Stated	Revision
5	p.9, §3.2 File Naming Conventions, 835 Transaction subsection	This is the batch 835 file available for download (in X12 format). Refer to Section 2, 835 Claims Remittance Advice Transaction, for additional information. AZ-835-01-YYYYMMDD-HHMMSS-PROVID.TXT • AZ is the state code • 835 is the Transaction code • 01 is the 835 File • YYYYMMDD is the process date • HHMMSS is the time expressed in 24-hour clock time • PROVID is the Provider ID • TXT is the file extension	This is the batch 835 file available for download (in X12 format). Refer to Section 2, 835 Claims Remittance Advice Transaction, for additional information. AZ-835-01-YYYYMMDD-HHMMSS-PROVID-L.TXT • AZ is the state code • 835 is the Transaction code • 01 is the 835 File • YYYYMMDD is the payment date • HHMMSS is the time expressed in 24-hour clock time • PROVID is the Provider ID • L is the Location Code • TXT is the file extension
6	p.12, §4.1 General Information, Other Standards subsection heading	Other Standards	Balancing Financial Data
7	p.15, §4.2 Testing Procedures	AHCCCS has established a policy regarding inclusion of the 835 Transaction standard testing by receivers. There are three options that may be used in the generation of test claims to generate 835 test files for retrieval and review by the receiver: Option 1 – Submission of an 837 test file Option 2 – Submission of paper test claims Option 3 – AHCCCS entry of paper test claims Please refer to the AHCCCS Electronic Remittance Advice Manual for further information.	AHCCCS has established a policy regarding inclusion of the 835 Transaction standard testing by receivers. AHCCCS will provide test 835 files that are parallel to production data so that trading partners can process accordingly. AHCCCS requires each trading partner receive a minimum of two test files before being granted production status.
8	p.19, §4.3 Data Interchange Conventions, Envelope Transaction Specifications, Valid Value and Definition/Format columns for Element ISA16, 1st paragraph	| A “pipe” (the symbol above the backslash on most keyboards) is the value used by AHCCCS for component separation. Segment and element level delimiters are defined by usage in the ISA Segment and do not require separate ISA elements to identify them.	<deleted>
9	p.35, §5.2 835 Claims Remittance Advice	In addition to supporting financial adjustments (changes from charged to paid amounts) at claim and	As a remittance advice, the 835 provides detailed payment information relative to a health care claim(s) and, if

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	Transaction Specifications, Provider Level Adjustments subsection	service line levels, the 835 Transaction's PLB Provider Adjustment Segment allows claim payers to notify billing providers of payments and withholds that are not claim specific. AHCCCS uses the provider level adjustment feature in two ways: • To report non-claim specific payments to (and withholds from) billing providers. Settlements and returned checks are examples of items that can be handled by this segment. • To offset negative payment amounts to billing providers when the total provider payment balance on the 835 is negative. This function is needed because the AHCCCS Financial System does not issue negative payments. Payments to and withholds from billing providers that are not specific to claims are included in transaction level balancing along with claim based payments. They have PLB03 Adjustment Reason Codes of "AM" (Applied to Borrower's Account). The negative offset function also affects 835 balancing requirements. Negative offsets are needed when, on a particular claim payment cycle, recoveries from a billing provider add up to more than payments. In negative payment situations, AHCCCS creates a provider level offset adjustment in the PLB Segment with a PLB03 Adjustment Reason Code of "FB" (Forwarding Balance). The provider level adjustment is for a negative amount equal to the calculated negative amount of the recovery from the provider. A negative rather than a positive amount is required due to the 835 Transaction's balancing requirements. According to the 835 Implementation Guide (Page 169), "These adjustments can either decrease the payment (a positive	applicable, describes why the total original charges have not been paid in full. This remittance information is provided as "justification" for the payment. Claim and service information is contained within the detail loops and may occur multiple times to provide a logical grouping of the claim and service information. The 835 Transaction's PLB Provider Adjustment Segment allows claim payers to notify billing providers of payments and withholds that are not claim specific. AHCCCS uses the provider level adjustment feature in any of the following ways: • Early Payment Allowance (PLB03-1 = 90) Also known as the Quick Pay Discount. • Adjustment (PLB03-1 = CS) To report non-claim specific payments to (and withholds from) billing providers. Settlements and returned checks are examples of items that can be handled by this segment. To offset negative payment amounts to billing providers when the total provider payment balance on the 835 is negative. This function is needed because the AHCCCS Financial System does not issue negative payments. • Forwarding Balance (PLB03-1 = FB) A positive value (withhold to the provider) in PLB04 represents a balance that moves forward to a future payment advice. • Interest Owed (PLB03-1 = L6) Also known as the Slow Pay Penalty. PLB01 carries the Billing Provider Identifier (as identified in Loop 1000B at the beginning of the transaction). For Health Care Service Providers this will be their National Provider Identifier (NPI). Atypical Service Providers will

#	Location	Previously Stated	Revision
		number) or increase the payment (a negative number)." When the calculated Total Payment Amount on an 835 Transaction is negative, it must be offset with a corresponding increase in payment. The final payment amount in the BPR02 Total Actual Provider Payment Amount element on the 835 Transaction is then zero. PLB Offset Segments are created whenever a calculated total payment amount is negative. This can be due to either claim voids or replacements or to provider adjustments specified on other PLB Segments.	see their Legacy Identifier. The Invoice Number assigned by the AHCCCS Financial System is returned in PLB03-2.

#	Location	Previously Stated	Revision
10	p.37, §5.2 835 Claims Remittance Advice Transaction Specifications, a new subsection entitled NPI Contingency Plan following subsection Transaction Specifications Table	-	All AHCCCS system programming changes to support NPI implementation are complete, but AHCCCS is operating in an optional use period that allows providers to submit their Legacy Identifier number (any identifier previously used to identify a health care provider prior to NPI), their NPI number (that is known to the AHCCCS system) or both. <u>Dual Use</u> AHCCCS began to accept NPIs on transactions as of 1/1/2007. If the NPI is sent on a transaction, only the NPI is used to process the transaction even though a Legacy Identifier may be present on the transaction. For example, AHCCCS will not attempt to process a transaction using the Legacy Identifier if the NPI is present on the transaction but not on file with AHCCCS. If the NPI has not been registered/enrolled by AHCCCS, then the transaction will fail. Atypical service providers (those providers who do not provide traditional health care services such as non-emergency transportation) are not eligible for an NPI and should continue to use their existing Legacy Identifier. AHCCCS will continue to accept submission of both the NPI and/or other legacy identifiers until a future date*. * Monitor AHCCCS' web page (http://www.azahcccs.gov/hipaa/Documents/PDFs/NPIDocuments/) for the latest updates regarding the NPI Contingency Plan.

#	Location	Previously Stated	Revision
11	p.37, §5.2 835 Claims Remittance Advice Transaction Specifications, a new subsection entitled Group Health Care Service Providers following subsection NPI Contingency Plan	-	Group Health Care Providers are entities composed of one or more individuals generally created to provide coverage of patients' needs in terms of office hours, professional backup and support or range of services resulting in specific billing or payment arrangements. In the past, Group Billers could not submit their identifier in electronic claim submissions. With the advent of NPI usage, AHCCCS can now accept the Group NPI on electronic claim submissions (as is already the case with paper claim submissions). The Billing Provider's NPI is the NPI sent in the 2010AA (Billing Provider Name) loop of the 837 Claim Transactions. The claim adjudication system no longer attempts to establish a relationship between the biller's tax identification number and the service provider's identification number.
12	p.39, §5.2 835 Claims Remittance Advice Transaction Specifications, Loop 1000B, Valid Values and Definition/Format columns for Element N103	FI The payee's Federal Taxpayer's ID Number	FI The payee's Federal Taxpayer's ID Number XX National Provider ID
13	p.39, §5.2 835 Claims Remittance Advice Transaction Specifications, Loop 1000B, Definition/Format column for Element N104	Payee's Tax ID Number	After 05/22/2007, the National Provider ID will appear in this field. Prior to that date, this will be the Payee's Tax ID Number
14	p.40, §5.2 835 Claims Remittance Advice Transaction Specifications, Loop 1000B, Valid Values and Definition/Format columns for Element REF01	1D Medicaid Provider Number	TJ Federal Taxpayer ID Number Qualifier

#	Location	Previously Stated	Revision
15	p.40, §5.2 835 Claims Remittance Advice Transaction Specifications, Loop 1000B, 1st paragraph of Definition/Format column for Element REF02	The billing provider's AHCCCS ID.	Federal Taxpayer ID Number of the provider.
16	p.40, §5.2 835 Claims Remittance Advice Transaction Specifications, Loop 2000, Element TS301, Definition/Format column	The eight-character AHCCCS Provider Identification Number (including Location Code) for the rendering provider appears in TS301.	Atypical Service Providers The AHCCCS ID and Location Code of the provider. Health Care Service Providers The National Provider Identifier (NPI).
17	p.41, §5.2 835 Claims Remittance Advice Transaction Specifications, Loop 2100, Element CLP02, Valid Values and Definition/Format columns	1 Paid as Primary (Original Paid and Replacement Claims) 4 Denied 22 Reversal of Previous Payment (Void Claims and the void component of Replacement Claims) These are the Claim Status Code values used by AHCCCS on 835 Transactions. "Paid as Primary" indicates a normal payment. For claim reversals, two claims appear, one to void the original (CLP02 = "22") and the other to create a new replacement claim (CLP02 = "1").	1 Processed as Primary (Original Paid and Replacement Claims) 2 Processed as Secondary 3 Processed as Tertiary 4 Denied 22 Reversal of Previous Payment (Void Claims and the void component of Replacement Claims) These are the Claim Status Code values used by AHCCCS on 835 Transactions. "Processed as Primary" indicates a normal payment. For claim reversals, two claims appear, one to void the original (CLP02 = "22") and the other to create a new replacement claim (CLP02 = "1").
18	p.41, §5.2 835 Claims Remittance Advice Transaction Specifications, Loop 2100, Element CLP04, Definition/Format column	The AHCCCS Total Paid Amount for the claim.	The amount AHCCCS would have paid prior to any discounts or interest.
19	p.43, §5.2 835 Claims Remittance Advice Transaction Specifications, Loop 2100, Valid Values and Definition/Format columns for Element NM108 (of Rendering Provider)	MC Medicaid Provider Number	XX National Provider ID Qualifier

#	Location	Previously Stated	Revision
20	p.43, §5.2 835 Claims Remittance Advice Transaction Specifications, Loop 2100, Definition/Format column for Element NM109 (of Rendering Provider)	The six-character AHCCCS ID of the service provider followed by a two-character Provider Location Code.	National Provider ID
21	p.44, §5.2 835 Claims Remittance Advice Transaction Specifications, PLB Segment	<all elements within PLB segment>	<deleted> <see p.35 Provider Level Adjustments subsection for PLB information>

Table of Contents

1. Introduction

1.1 Document Purpose

Companion Documents

Companion Documents are available to external entities (health plans, program contractors, providers, third party processors, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with AHCCCS. The following Companion Documents are being produced:

- 834 Enrollment and 820 Capitation Transactions
- 270 Eligibility Verification and 271 Eligibility Response Transactions
- 837 Claim Transactions
- 837 and NCPDP Encounter Transactions
- *835 FFS Claims Remittance Advice Transaction*
- 276 Claim Status Request and 277 Claim Status Response Transactions
- U277 Unsolicited Encounter Status Transaction
- 278 Prior Authorization Transaction

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. They also address the security and privacy of health data. The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were not imposed arbitrarily but were developed by processes that included significant public and private sector input.

Covered entities are required to accept HIPAA Transactions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically. Both AHCCCS and its health plans are HIPAA covered entities.

Document Objective

This Companion Document provides information about the 835 Claims Remittance Advice (RA) Transaction that is specific to AHCCCS and AHCCCS trading partners. For this transaction, the document describes the ways in which claim submitters receive information from AHCCCS.

Intended Users

Companion Documents are intended for the technical staff of the AHCCCS trading partners that are responsible for electronic transaction/file exchanges.

Relationship to HIPAA Implementation Guides

Companion Documents supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This document describes the AHCCCS environment and interchange conventions for 835 Claims Remittance Advice Transactions. It also provides specific information on the fields and values required for transactions sent to AHCCCS.

Companion Documents are intended to supplement rather than replace the standard HIPAA Implementation Guide for each transaction set. Information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between AHCCCS and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize conflicts or errors; however, AHCCCS, the AHCCCS Information Services Division, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the AHCCCS Information Services Division immediately.

1.2 Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.
Transaction Overview	Section 2 provides an overview of the transactions included in this Companion Document including: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted AHCCCS files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with AHCCCS via electronic transactions. Readers are referred to the AHCCCS Electronic Claim Submission and Electronic Remittance Advice Requirements document for operational information.
Transaction Standards	Section 4 provides information relating to the transactions included in this Companion Document including: ▪ General HIPAA transaction standards ▪ Testing criteria and procedures ▪ Data interchange conventions applicable to the transactions ▪ Procedures for acknowledgment transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Specifications	Section 5 provides more specific information relating to the transaction included in this Companion Document including: ▪ A statement of the purpose of transaction specifications for electronic interchanges between AHCCCS and other HIPAA covered entities. ▪ Detailed Specifications that show how AHCCCS populates the data elements in the 835 Claim Remittance Advice Transaction when AHCCCS uses transaction data elements in ways that are not fully described by information in a HIPAA Implementation Guide.

2. 835 Claim Remittance Advice Transaction

2.1 Transaction Overview

Claim Remittance Advice Transaction

The HIPAA Implementation Guide for the 835 Health Care Claim Payment/Advice Transaction describes the transaction's "business use and definition" in the following way:

> The 835 is intended to meet the particular needs of the health care industry for the payment of claims and transfer of remittance information. The 835 can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice from a health care payer to a health care provider, either directly or through a DFI [Depository Financial Institution].

The 835 Transaction (sometimes called the Claims Remittance Advice or Claims RA Transaction in the remainder of this document) is a claims payment reporting transaction. It tells claim submitters the results of payer adjudication at the claim and service line levels.

The 835 Transaction differs from the pre-HIPAA AHCCCS Claim Remittance Advice in that it does not report on claims that have not yet been processed or have been pended by the AHCCCS Prepaid Medical Management Information System (PMMIS). In the HIPAA environment, submitters can obtain the statuses of all their claims, including claims that have not yet completed adjudication, with the Web-based 276 Claim Status Request Transaction.

Each 835 Claim RA Transaction must correspond to a payment by electronic transfer or check. Because payments are made from AHCCCS bank accounts, providers that treat patients with AHCCCS funding sources for which AHCCCS maintains separate accounts (currently Acute Services, Long Term Care, and KidsCare) receive a weekly 835 Transaction for each account from which they are due payment.

835 RA Transactions and 837 Claim Transactions are closely linked. Although data on 835 Transactions comes from the PMMIS Database and the AHCCCS Financial System, much of it is derived from information on incoming 837s, with the addition of Payment Amounts, Adjustment Reason Codes, and Remark Codes generated by PMMIS for the AHCCCS translator. Any change from a billed amount to a paid amount at a claim or service

line level is called an adjustment in HIPAA nomenclature and is reported on the 835 with an Adjustment Reason Code and an Adjustment Amount.

Adjustment Reason Codes occur at institutional claim and professional/dental service line levels. In addition, the 835 Transaction supports HIPAA compliant Remark Codes for denials at both levels. Remark Codes are not directly associated with changes from billed to payment amounts but are used to provide additional information about claim and service line errors.

Because of the frequent gaps between meanings of the several types of claim adjudication codes used by AHCCCS and the codes on the 835 Transaction, AHCCCS posts a sequential Remittance Advice Supplemental File to the Web Server along with the 835 Transaction. The Supplemental File carries claim identification information and the original adjudication codes generated for each claim or service line by PMMIS. The Supplemental File is described in detail in Section 4.5, 835 Supplemental File.

Processes Replaced or Impacted

The primary process affected by the 835 Claim Remittance Advice Transaction is the creation and transmission of the claim remittance advice.

835 Claim Remittance Advice Transaction

Replaced Files
Electronic Claim Remittance Advice File

Impacted Files
None

2.2 835 Claim Remittance Advice Transaction

Standard Implementation Guide

The standard Implementation Guide for the 835 Claim Remittance Advice Transaction is the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Transaction Set Implementation Guide for the Health Care Claim Payment/Advice and all approved Addenda. Versions of the 835 Implementation Guide and Addenda adopted by AHCCCS and other covered entities and used in preparation of this document are:

- ASC X12N 835 (004010X091)
- ASC X12N 835 (004010X091A1) (Addenda)

Related Transactions

HIPAA-mandated 837 Claim Transactions provide some of the claim data that AHCCCS returns to claim submitters on 835 Remittance Advice Transactions.

Transmission Schedules

AHCCCS sends 835 Remittance Advice Transactions to its receivers on a weekly basis. They are issued at the same time as claim payments.

3. Technical Infrastructure and Procedures

3.1 Technical Environment

AHCCCS Data Center Communications Requirements

Authorized receivers of 835 Claim Remittance Advice Transactions can either view and download 835 Transactions from the AHCCCS Web Server or may elect to receive 835 Transactions via FTP. Please refer to the AHCCCS Electronic Remittance Advice Manual for further information.

Technical Assistance and Help

The AHCCCS Information Services Division (ISD) Customer Support Center provides technical assistance related questions about electronic data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** (602) 417-4451
- **Hours:** 8:00 AM – 5:00 PM Arizona Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (setup, procedures, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Customer Support Center

3.2 File Naming Conventions

File Naming Conventions

835 Transaction Overview

```
AZ-835-01-20031113-054321-020107-1.TXT  835 File
AZ-835-02-20031113-054321-020107-1.TXT  Supplemental File
^  ^   ^      ^       ^      ^   ^  ^
|  |   |      |       |      |   |  |-- File Extension
|  |   |      |       |      |   |----- Location Code
|  |   |      |       |      |--------- Provider ID
|  |   |      |       |----------------- Time
|  |   |      |------------------------- Payment date
|  |   |------------------------------- File Type
|  |---------------------------------- Transaction Code
|------------------------------------- State Code
```

835 Transaction

This is the batch 835 file available for download (in X12 format). Refer to Section 2, 835 Claims Remittance Advice Transaction, for additional information.

AZ-835-01-YYYYMMDD-HHMMSS-PROVID-L.TXT

- AZ is the state code
- 835 is the Transaction code
- 01 is the 835 File
- YYYYMMDD is the payment date
- HHMMSS is the time expressed in 24-hour clock time
- PROVID is the Provider ID
- L is the Location Code
- TXT is the file extension

Supplemental File

The supplemental file provides additional claim adjudication information not available within the 835 Transaction. This file is not required for determining the status of a claim, but it does provide additional detailed information that Providers may find helpful. Refer to Section 4.5, 835 Supplemental File, for additional information.

AZ-835-02-YYYYMMDD-HHMMSS-PROVID.TXT

- AZ is the state code
- 835 is the Transaction code
- 02 is the Supplemental File
- YYYYMMDD is the process date
- HHMMSS is the time expressed in 24-hour clock time
- PROVID is the Provider ID
- TXT is the file extension

4. Transaction Standards

4.1 General Information

HIPAA Requirements

HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. Currently, the 835 Claims Remittance Advice Transaction has a draft Addendum (although, for this transaction, it is brief and has little impact). It has been adopted as final and incorporated into AHCCCS requirements for the 835 Transaction.

An overview of requirements specific to the 835 Transaction can be found in Section 2, Data Overview, of the 835 Implementation Guide. The Data Overview Section contains information related to:

- Format and content of interchanges and functional groups
- Format and content of the header, detailer and trailer segments specific to the transaction
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

Size of Transmissions/ Batches

Transmission sizes are limited based on two factors:

- The number of segments recommended by HIPAA Implementation Guides and imposed by lengths of control fields within transactions
- AHCCCS file transfer limitations

Recommended HIPAA standards for the maximum file size of each transaction are specified in the appropriate Implementation Guide or its authorized Addendum. The 835 Implementation Guide recommends a maximum of 10,000 CLP (Claim Payment) Segments per transaction.

For postings to the Web Server, AHCCCS has a file length limitation of ten-megabytes (about the quantity of data carried on seven three and one half inch diskettes). AHCCCS will contact the receiver if an 835 Transaction exceeds the ten-megabyte limit, and that receiver will be required to change their 835 election to FTP.

FTP Solution for Oversized Files

There is a four-megabyte download file size limitation. Files over four-megabytes cannot be moved via the AHCCCS Online option. For those providers whose file size will exceed four-megabytes, an FTP option is available. Please contact AHCCCS Information Services Division (ISD) Customer Support Center for the appropriate paperwork to request this option. Please note that a provider can use either the AHCCCS Online download or FTP, but not both. Once the option to download files via FTP is processed, files will not be available for online download or viewing.

Balancing Financial Data

There are two types of balancing procedures that affect the 835 Transaction. They are internal and external to the transaction.

- Internal Balancing within the 835 Transaction

The 835 Implementation Guide discusses balancing within the 835 Transaction by presenting it in three hierarchical levels:

- Service Line
- Claim
- 835 Transaction

At the professional/dental service line level, balancing is between the amount charged for the service, any line-level adjustment made to the charged amount, and the service line payment amount. The 835 Implementation Guide translates these requirements into specific data elements that carry Charged Amounts, Adjustment Amounts, and Paid Amounts. Each Paid Amount must always equal to the Charged Amount minus the Adjustment Amount.

For professional/dental claims, all payer initiated CAS Segment adjustments (Adjustment Reason Code = “PI”) are at the service line level. Claim level amount fields, when populated, are summaries of service line amounts and do not affect balancing.

For institutional claims, balancing is only at the claim level. The claim-level Paid Amount is the amount adjudicated for the entire institutional claim. The difference between these amounts is the claim level Adjustment Amount. Service line data may be present for inpatient institutional claims on 835 Transactions, but AHCCCS always pays the claims at the claim header level.

At the transaction level, the Total Payment Amounts for all claims in a transaction must equal the sum of all claim-level Payment Amounts plus or minus PLB Segment provider level adjustments, such as settlements, that are not claim-specific. PLB Segment provider level adjustments can be positive or negative.

For all levels of balancing, positive Adjustment Amounts are subtracted from amounts charged by the provider to create Payment Amounts. Negative Adjustment Amounts, should they occur, are negative to AHCCCS and are added to the amounts charged by the provider.

For the 835 Transaction, each institutional claim or professional/dental service line becomes a unique CLP Claim Payment Segment with its own unique 14-digit Claim Reference Number (CRN). For professional and dental claims, the last two digits of the 14-digit CRN are for the Service Line Number.

Inpatient nursing home claims with additional services are sometimes priced at both claim and line levels. The AHCCCS 835 Transaction accommodates this situation because it creates claim and line level loops for every service line.

- Balancing between the 835 Transaction and External Sources

External balancing involves comparisons between data on 835 Transactions and payment amounts generated by the vouchers that contribute to weekly provider payments. AHCCCS maintains separate bank accounts and issues separate vouchers and 835 Transactions for various payment sources (currently Acute Care, LTC, and KidsCare). The total amount of the payment to the receiver from each payment source (Element BPR02) is derived from the same voucher amounts that are used to generate the receiver's check. Amounts should always match.

Remittance Tracking

The Trace Number (Element TRN02) and the Payer Identification Number (Element TRN03) in the 835 Transaction's Reassociation Trace Number (TRN) Segment can be used to reassociate the remittance advice data in the 835 Transaction with the payment sent separately by the AHCCCS Financial System. For AHCCCS, TRN02 is the Payment Number of the electronic transfer or check written for provider payment by the AHCCCS Financial System.

Claims and Service Lines

As used by AHCCCS, the structure of the 835 Transaction defines institutional claims at the claim header level and professional and dental claims at the service line level. Each CLP Claim Payment Segment on the 835 Transaction represents an adjudicated payment or denial, an entire multi-line invoice for an institutional claim and a single service for a professional or dental claim. AHCCCS "splits" multi-line professional and dental claims and gives each CLP Claim Payment Segment its own unique, 14-digit Claim Reference Number.

In most cases, these conventions correspond to the level at which charged amounts are "adjusted" on the 835 Transaction's CAS Adjustment Segments to become Payment Amounts. For professional and dental claims, adjustments are always at the service level. For institutional claims, there are exceptions to the invoice claim header level payment rule that cause pricing (but not payment) to be at the service level. In these cases, the 835 Transaction shows line level adjustments that contribute to the single invoice claim header level payment:

- Outpatient Institutional Claims
- Inpatient Institutional Claims Paid as Tier Outliers
- Inpatient Institutional Claims Paid on a Cost to Charge Ratio

Nursing home institutional claims can be paid by both daily rates and, at the line level, by payments for ancillary services that are not included in the daily rate. In this situation, it is possible for a claim to have both claim header level and line level adjustments.

4.2 Testing Procedures

Testing Procedures	AHCCCS has established a policy regarding inclusion of the 835 Transaction standard testing by receivers. AHCCCS will provide test 835 files that are parallel to production data so that trading partners can process accordingly. AHCCCS requires each trading partner receive a minimum of two test files before being granted production status.

4.3 Data Interchange Conventions

Overview of Data Interchange

When transmitting 835 Transactions to providers, AHCCCS follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 835 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B of Implementation Guides.

Transaction Agreements that specify how individual data elements are populated by AHCCCS on ISA/IEA and GS/GE envelopes are shown in the table in this section. This document assumes that security considerations involving user identifiers, passwords, and encryption procedures are handled by the AHCCCS FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Translation Specifications Table

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values
The valid values from the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Characters	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 characters		Leave field blank – not used by AHCCCS.
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 characters	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters		Leave field blank – not used by AHCCCS.
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 characters		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number (866004791)
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 characters		The six-digit AHCCCS Provider ID
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 characters	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		The Interchange Control Number. ISA13 must be identical to the control number in associated Interchange Trailer field IEA02.
NA	ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	0	No Acknowledgement Requested AHCCCS does not request or expect TA1 Interchange Acknowledgement Segments from its trading partners.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P or T	Production Data or Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character		Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by AHCCCS on outgoing transactions: Segment Delimiter - "~' (tilde – hexadecimal value X"7E") Element Delimiter - "{" (left rounded bracket – hexadecimal value X"7B") Composite Component Delimiter (ISA16) - "|" (pipe – hexadecimal value X"7C") These values are used because they are not likely to occur within transaction data.
IEA INTERCHANGE TRAILER						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 characters		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	HP	Health Care Claim Payment/Advice (835)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		AHCCCS repeats the Sender Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		AHCCCS repeats the Receiver Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		004010X091A1 AHCCCS uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the final Addenda.	HIPAA Code Set
GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

4.4 Acknowledgment Procedures

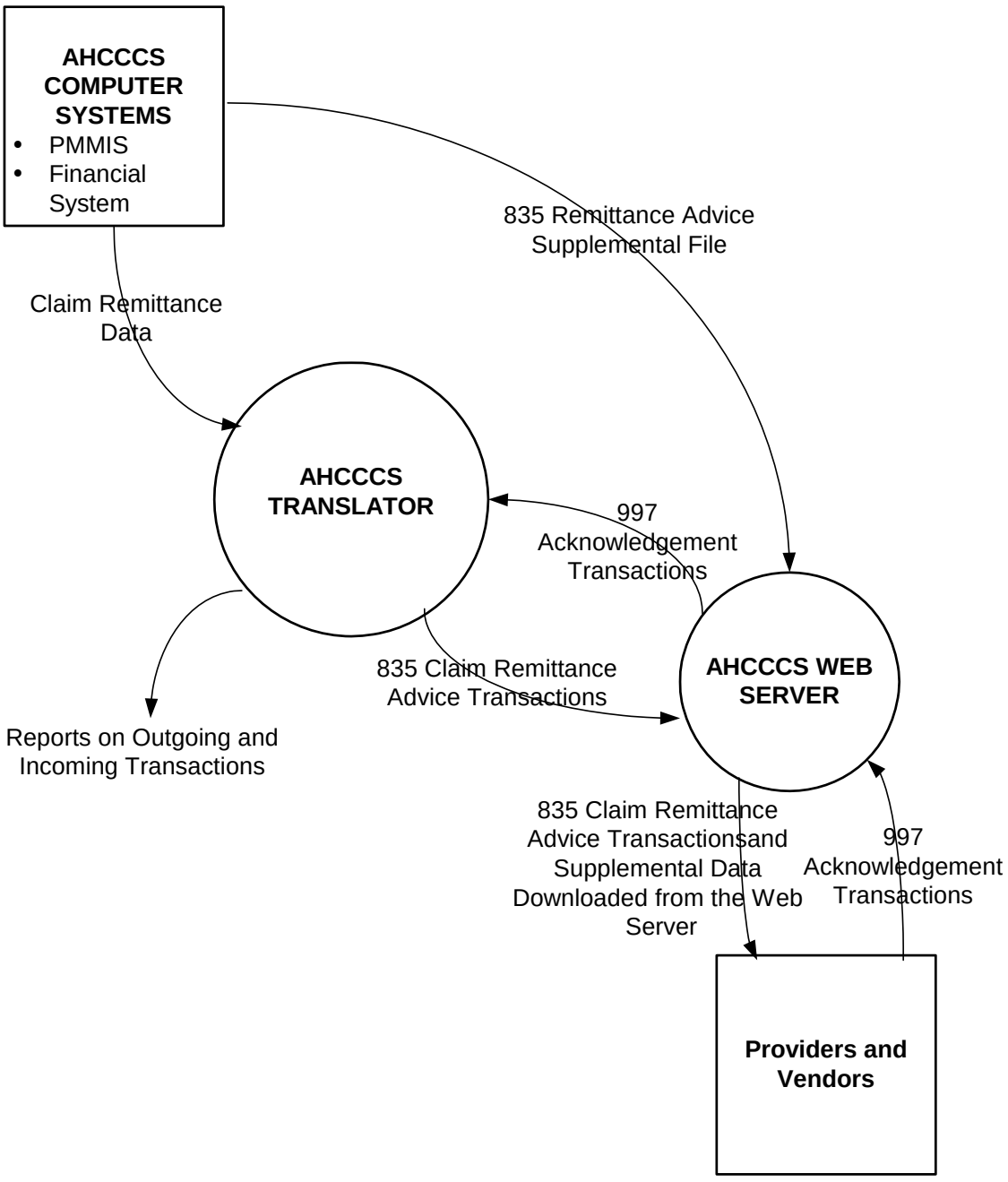
Overview of Electronic Acknowledgment Processes

The following diagram, AHCCCS Interchange Flow for 835 Transactions, shows the relationships between AHCCCS and providers who receive batch Web-based 835 RAs. All 835 Transactions go through the AHCCCS translator and the AHCCCS Web Server. Transactions from AHCCCS that fail translator edits are corrected prior to transmission. For each 835 Transaction, AHCCCS transmits claim pricing and adjudication codes generated by PMMIS in the sequential 835 Remittance Advice Supplemental File.

AHCCCS accepts and processes 997 Functional Acknowledgement Transactions from receivers of 835s. They can return 997s through the AHCCCS FTP Server as either acknowledgements or as notifications of syntactical problems. AHCCCS does not anticipate extensive syntactical problems because it applies translator edits to outgoing and well as incoming transactions and corrects any problems revealed by the translator prior to 835 transmission. Discrepancies are possible, however, due to variations in sender and receiver edits.

If requested by 835 receivers, AHCCCS posts an 835 Remittance Advice Supplemental File to the FTP Server along with each 835 Transaction. The Supplemental File carries HPMMIS adjudication codes as they are generated prior to 835 translation. It is described more fully in Section 4.5, 835 Supplemental File.

AHCCCS Interchange Flow for 835 Transactions



4.5 835 Supplemental File

Supplemental File Summary

A basic purpose of all claim remittance advices, including the 835 Transaction, is to communicate to claim submitters the reasons why billed services are paid or denied. Both the current paper RA used by AHCCCS and the electronic 835 RA Transaction have many adjudication code values and messages that serve this purpose.

Frequently, however, HIPAA offers no reasonable translation for detailed AHCCCS Pricing, Edit, and Reason Codes. For this reason, AHCCCS has created an 835 Remittance Advice Supplemental File to accompany each 835 Transaction. The Supplemental File supplies all of the claim or service line pricing and adjudication codes that are generated by PMMIS prior to translation and that are included on paper RAs. The file is available to 835 receivers that request it.

In terms of claim level and line level information, the Supplemental File follows the structure of the AHCCCS 835 Transaction. Claims are defined as multi-line invoices for institutional claims and single services for professional and dental claims.

Institutional claims have only claim header data on the Supplemental File because that is the level at which adjudication messages are generated by PMMIS. This is the case even when the 835 includes line level pricing and adjustment data for outpatient institutional claims and inpatient claims paid on a cost-to-charge basis. Professional and dental claims have both header and line data on the Supplemental File.

The 835 Supplemental File is a fixed-length sequential file with 197 byte records. It is more similar in structure to pre-HIPAA AHCCCS interface files than to the 835 Transaction. It has four record types:

- A single Header Record with identification information on the payer and billing provider
- Multiple Claim Report Records with Patient Account Numbers, AHCCCS Claim Reference Numbers (CRNs), and PMMIS adjudication codes within each PMMIS Comment Type
- A single Processing Notes Record with PMMIS adjudication code descriptions for all PMMIS adjudication codes generated for claims submitted by a billing provider
- A single Trailer Record with a control count

A single Header and Trailer Record appears at the beginning and end of each Supplemental File. A Claim Report Record appears for each institutional invoice or professional/dental service. A Processing Notes Record is created for each billing provider. It provides messages associated with the PMMIS adjudication codes on the billing provider's Claim Report Records.

Data element level information on the 835 Supplemental File appears in the remainder of this section.

835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
HEADER RECORD – 1 record per 835 Transaction				
Header	Record Type	A code for one of the four Record Types on the 835 Supplemental File	2/AN	"HR" = Header Record
Header	File Name	A descriptive name for the file	35/AN	"REMITTANCE ADVICE SUPPLEMENTAL FILE"
Header	Payer Name	The name of the claim payer	50/AN	"ARIZONA"
Header	Payer's Tax ID	The Federal Tax ID of the claim payer	20/AN	"866004791"
Header	Billing Provider ID	The AHCCCS Identification Number assigned to the Billing Provider	8/AN	
Header	Billing Provider Name	The name of the Billing Provider	25/AN	The full name of the billing provider with intervening spaces between name components
Header	Billing Provider Tax ID	The Federal Tax ID of the Billing Provider	20/AN	
Header	Filler		37/AN	Filled with spaces
CLAIM REPORT RECORD – 1 or more records per 835 Transaction				
Claim Report	Record Type	A code for one of the four Record Types on the 835 Supplemental File	2/AN	"S1" = Claim Report Record
Claim Report	Patient Account Number	The claim submitter's ID Number for the patient	20/AN	
Claim Report	AHCCCS Claim Number	The Claim Reference Number (CRN) or Service Line Reference Number assigned by AHCCCS	14/AN	For institutional claims reported at the claim level, the final two characters are zeros. For professional and dental service lines, the final two characters carry the Line Number with a value of more than zero**.**
Claim Report	Recipient ID	The AHCCCS ID Number for the recipient	10/AN	The nine-character AHCCCS Recipient ID
Claim Report	Claim Status Code	The claim or line level status code	1/AN	For institutional claims, this Status Code is always at the claim level. For professional and dental claims, it is at the service line level without an equivalent claim level code on the 835. Valid values are: • "1" = Paid • "2" = Adjusted • "3" = Voided • "4" = Denied
Claim Report	Claim Status Date	The date on which the PMMIS Status Code from which the Claim Status Code is derived was assigned.	8/AN	Format is CCYYMMDD.

835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
Claim Report	Comment Type	An AHCCCS code for the type of comment in the Comment Text field.	2/AN	Code values correspond to the four Comment Type descriptions identified below.
Claim Report	Comment Text	A field defined separately for each type of Comment generated by PMMIS.	140/AN	A description of the PMMIS Comment Type appears at the beginning of each comment. Comment Types identified by descriptions are: • PRICE EXPL – An explanation of the pricing methodology used to price the claim or service line, for example, “APD” for Ancillary Per Discharge Rate on an inpatient claim. • REASON CDS – Claim Reason or Edit/Result Codes generated by PMMIS to explain denials and payment cut-backs, for example “H129.2” for Primary Diagnosis Code is Invalid for Recipient Age. • TIER DATA – The pricing tier or tiers at which an inpatient claim is paid, for example “SUR” for Surgery Tier. • COMMENTS – Additional comments entered by reviewers, for example, “OUTLIER REQUESTED, NOT QUALIFIED”. Descriptions of all codes used on an 835 Transaction appear in the Processing Notes Record. Layout for the comment text field follows: NOTE: The Comment Text field contains different formats, depending on the Comment Type. Comment Type ‘A’: There are three different formats for this type: (1) Price Explanation Code 3 characters 10 Occurrences of X(14) Price Explanation Reason 2 characters Filler 9 characters (2) Price Explanation Ind. 1 character 10 Occurrences of X(14) Price Explanation Rate 3 characters Filler 10 characters (3) Filler 1 character 10 Occurrences of X(14) Price Expl. Type Ind. 1 character Price Explanation Type 3 characters Filler 9 characters

835 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
				Comment Type 'R': There is one format for this type: (1) Reason Code 6 characters 17 Occurrences of X(8) Filler 2 characters Comment Type 'T': There is one format for this type: (1) Tier 1 5 characters 1 Occurrence of X(140) Filler 51 characters Reason 1 5 characters Filler 8 characters Tier 2 3 characters Filler 53 characters Reason 2 5 characters Filler 10 characters Comment Type 'X': Used to indicate free form. There is no format for this type.
PROCESSING NOTES RECORD – 1 record per 835 Transaction				
Notes	Record Type	A code for one of the Record Types on the 835 Supplemental File	2/AN	"S2" = Processing Notes Record
Notes	Processing Note Code	An AHCCCS Adjudication Code that appears in the Comment Text Field on Claim Records.	6/AN	A PMMIS claim or service line adjudication code that appears in the Comment Text field of a Claim Report Record for a billing provider.
Notes	Processing Note Description	The message associated with the AHCCCS Adjudication Code.	140/AN	A description of the claim or service line adjudication code. Code values generated for all claims for a billing provider are unduplicated.
Notes	Filler		49	
TRAILER RECORD – 1 record per 835 Transaction				
Trailer	Record Type	A code for one of the Record Types on the 835 Supplemental File	2/AN	"TR" = Trailer Record
Trailer	Trailer Record Count	The number of records in the 835 Supplemental File, including the Header and Trailer Records.	9/N	
Trailer	Filler		186	

5. Transaction Specifications

5.1 About Transaction Specifications

Purpose

Transaction Specifications document the codes that AHCCCS allows between trading partners and specify the type and format of the information included in data elements. In some cases, these values are subsets of the data element values listed or referenced in Implementation Guides. In others, they are specific to AHCCCS requirements.

For example, in the Subscriber Number Loop of a transaction in the Implementation Guide, Element REF02 is defined as an alphanumeric identification element that is between 1 and 30 characters long. In the Transaction Specifications, REF02 is defined as the member's AHCCCS ID. The length and format of the field are based on the characteristics of the AHCCCS Recipient ID rather than on the variable field size defined for the transaction by the Implementation Guide.

Relationship to HIPAA Implementation Guides

Transaction Specifications supplement information in the Implementation Guides for each HIPAA Transaction with additional information specific to the trading partners using the transaction.

The information in the Transaction Specifications is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2 835 Claims Remittance Advice Transaction Specifications

Overview

The purpose of these Transaction Specifications is to identify the data elements used in the 835 Claims Remittance Advice Transaction so that providers and other entities that receive 835 Transactions from AHCCCS will be able to understand and process transaction data. The 835 Transaction does not include or accompany claim payments. Rather, it serves as a detailed remittance advice that shows payments, adjustments, and denials for each claim submitted by providers that choose to receive 835s.

The AHCCCS Financial System implements Agency policy by generating weekly electronic payments or checks to providers paid on a fee-for-service basis. To be consistent with this payment policy, the Agency generates 835 Transactions on a weekly basis. Each 835 includes identification, medical, and financial data on paid and denied claims adjudicated during the previous week. Pended claims and claims received but not yet processed by AHCCCS are not included. Claim replacements and voids are identified and reported but do not appear in separate sections.

The following entities can receive 835 Transactions from AHCCCS:

- Authorized fee-for-service providers that submit claims to AHCCCS
- Provider groups that serve as billing providers for individual physicians or other practitioners
- Billing agents that transmit claims and collect receivables for fee-for-service providers

Three special considerations that affect the AHCCCS 835 Transactions are discussed in further detail. They are:

- Claim Adjudication Codes
- Billing and Servicing Providers
- Provider Level Adjustments

Claim Adjudication Codes

The most important data variations between the current AHCCCS Claims Remittance Advice and the 835 Transaction are in the code sets that tell claim submitters the results of each claim's adjudication. On its pre-HIPAA RAs, AHCCCS relied on several code sets to inform submitters of claims and service lines that are paid, denied, pended, and not yet processed.

Detailed mappings between AHCCCS and HIPAA claim adjudication codes are posted to the AHCCCS Web Site as HIPAA Work Papers. These mappings are used in code set translation. They only apply to AHCCCS codes for which there are appropriate and reasonable translations. The following categories of AHCCCS Edit/Result and Claim Reason Codes have been excluded from the code set mappings:

- AHCCCS Codes for pended and not-yet-processed claims and service lines
  The 835 is a financial transaction that supports only adjudicated (paid or denied) claims and service lines.

- AHCCCS Codes for claim adjustments and voids
  Although the 835 Transaction supports replacements and voids, it does not have detailed Adjustment Reason or Remark Code to explain them. They are identified in other ways.

- AHCCCS Codes that cannot be reasonably translated
  Both AHCCCS and HIPAA Code Sets have some values that are not at all equivalent. These values have been dropped from the mapping. One of a set of standard Adjustment Reason Codes appears for financial adjustments even when AHCCCS codes are untranslatable. Additional information is communicated through Remark Codes on the 835.

On the HIPAA code set side, there are also three code sets that describe the results of claim adjudication: Adjustment Group Code, Adjustment Reason Code, and Remark Code. Adjustment Group and Adjustment Reason Codes explain the differences between Charged Amounts and Paid Amounts at both claim and service line levels. For the 835, adjustments are variations between Charged and Paid Amounts that result from claim adjudication.

High-level Adjustment Group Codes and more specific Adjustment Reason Code are associated with an Adjustment Amount on the 835 Transaction. Remark Codes have no direct relationship to dollar amounts, although many Remark Codes explain why a claim or service line is denied.

There are major differences between the AHCCCS and the HIPAA compliant code sets used to explain the results of claim adjudication. Two kinds of distinctions are especially important:

- AHCCCS pays most claims based on Allowed Amounts determined by PMMIS independently of provider charges. The only connection between charges and payments is that AHCCCS does not pay more than the Charged Amount even if the AHCCCS Allowed Amount is greater.

- Few AHCCCS and HIPAA code set values have solid, unambiguous matches at the same level of detail. This is true both because AHCCCS codes are more detailed and specific than HIPAA codes and because they frequently cover different situations.

In light of these considerations, AHCCCS has adopted a three-step approach to population of Adjustment Group, Adjustment Reason, and Remark Codes on 835 Transactions.

Step 1: Determine whether a claim or service line needs a CAS (Claim or Service Line Adjustment) Segment with an Adjustment Group Code, Adjustment Reason Code, and Adjustment Amount.

When the Payment Amount for a claim or line is different from the Charged Amount, a CAS Segment is required. When the amounts are equal, the CAS Segment with its adjustment codes is not needed.

In theory, a Remark Code can occur without a CAS Segment for a claim or service line. In practice, this seldom happens because most Remark Codes explain reasons for denials or cut-backs that generate adjustment codes and Adjustment Amounts.

Step 2: If Charged and Payment Amounts for an institutional claim or professional/dental service line are different, Adjustment Group and Adjustment Reason Codes are required on the 835 Transaction, along with an Adjustment Amount.

Adjustment code combinations are based on two factors. The first factor is the status categories that are assigned to institutional claims and professional/dental service lines by PMMIS:

- Original Paid Claims or Service Lines
- Replacement Claims
- Voided Claims
- Denied Claims or Service Lines

The second factor in adjustment code assignment is the reason for the adjustment. The following adjustment types (in addition to provider level adjustments that are not claim specific) are accommodated:

- Share of Cost Amounts paid by the patient
- Amounts paid by other health care carriers
- Amounts previously paid by AHCCCS
- Pricing adjustments - reductions in Payment Amounts from Charged Amounts due to use of AHCCCS Allowed Amounts in payment

Adjustment Group and Adjustment Reason Codes and messages used by AHCCCS on the 835 Transaction are shown in the chart on the next page.

Step 3: Translate AHCCCS Code Sets.

The third step occurs only for denied institutional claims and denied professional/dental service lines. It involves translation of AHCCCS Reason Codes to HIPAA Remark Codes on the 835 Transaction. Further translations of AHCCCS codes to Adjustment Group and Reason Codes are not attempted.

Remark Codes populate MIA (inpatient) and MOA (outpatient) Segments at the institutional claim level and LQ (Health Care Remark Codes) Segments when generated at the service line level. AHCCCS “unduplicates” Remark Codes for the 835 Transaction. This means that each code value appears only once for a claim or service line even when the same HIPAA code value is generated repeatedly.

Status Category	Adjustment Type	835 Adjustment Group	835 Adjustment Reason
Original or Replacement	Share of Cost	"PR" – Patient Responsibility	"2" – Coinsurance Amount
Original or Replacement	Other Carrier	"OA" – Other Adjustment	"23" – Payment adjusted because charges have been paid by another payer.
Original or Replacement	Prior AHCCCS Payment	"OA" – Other Adjustment	"B13" – Previously paid. Payment for this claim/service may have been provided in a previous payment.
Original or Replacement	Pricing	"PI" – Payer Initiated	"A2" - Contractual Adjustment
Void	Share of Cost	"CR" – Correction and Reversals	"2" – Coinsurance Amount
Void	Other Carrier	"CR" – Correction and Reversals	"23" – Payment adjusted because charges have been paid by another payer.
Void	Prior AHCCCS Payment	"CR" – Correction and Reversals	"B13" – Previously paid. Payment for this claim/service may have been provided in a previous payment.
Void	Pricing	"CR" – Correction and Reversals	"A2" - Contractual Adjustment
Denial	Pricing	"PI" – Payer Initiated	"A1" – Claim denied charges

All of these conditions can occur at both claim and service line levels. Inpatient institutional claims with tier-based pricing are priced and adjusted at the claim header level. All other claims are priced and adjusted by service line.

Billing and Servicing Providers

AHCCCS has two kinds of situations involving Billing and Servicing or Rendering Providers that require recognition in the 835 Transaction. They are:

- Rendering Providers with multiple locations – the Rendering Provider is also the Billing Provider.

  In this situation, the provider's AHCCCS ID Number, without a Location Code suffix, appears as the Billing Provider (Loop 1000B/Element REF02 in the Payee Additional Identifier REF Segment). The Provider IDs for the various locations appear, with Location suffixes, as service providers (Loop 2000/Element TS301and Loop 2100/Element NM109 in the Rendering Provider Name NM1 Segment).

- Provider Groups and Billing Agents – the Rendering Provider and Billing Provider are different.

  In this situation, AHCCCS assigns Provider IDs to the group or billing agent. The group or billing agent appears on the 835 as a Billing Providers Provider (Loop 1000B/Element REF02 in the Payee Additional Identifier REF Segment) without a Location Code. Members of the group have different AHCCCS Provider IDs. They appear as Rendering Providers (Loop 2000/Element TS301and Loop 2100/Element NM109 in the Rendering Provider Name NM1 Segment) with Location Codes.

If a rendering provider with multiple locations is a member of a billing group, the group is the billing provider on the 835 and each location is a different rendering provider.

Provider Level Adjustments

As a remittance advice, the 835 provides detailed payment information relative to a health care claim(s) and, if applicable, describes why the total original charges have not been paid in full. This remittance information is provided as "justification" for the payment. Claim and service information is contained within the detail loops and may occur multiple times to provide a logical grouping of the claim and service information.

The 835 Transaction's PLB Provider Adjustment Segment allows claim payers to notify billing providers of payments and withholds that are not claim specific.

AHCCCS uses the provider level adjustment feature in any of the following ways:

- Early Payment Allowance (PLB03-1 = 90)
  Also known as the Quick Pay Discount.
- Adjustment (PLB03-1 = CS)
  To report non-claim specific payments to (and withholds from) billing providers. Settlements and returned checks are examples of items that can be handled by this segment.
  To offset negative payment amounts to billing providers when the total provider payment balance on the 835 is negative. This function is needed because the AHCCCS Financial System does not issue negative payments.
- Forwarding Balance (PLB03-1 = FB)
  A positive value (withhold to the provider) in PLB04 represents a balance that moves forward to a future payment advice.
- Interest Owed (PLB03-1 = L6)
  Also known as the Slow Pay Penalty.

PLB01 carries the Billing Provider Identifier (as identified in Loop 1000B at the beginning of the transaction). For Health Care Service Providers this will be their National Provider Identifier (NPI). Atypical Service Providers will see their Legacy Identifier.

The Invoice Number assigned by the AHCCCS Financial System is returned in PLB03-2.

Transaction Specifications Table

835 Claims Remittance Advice Transaction Specifications for individual data elements are shown in the table beginning on the next page. Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
The valid values from the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

NPI Contingency Plan

All AHCCCS system programming changes to support NPI implementation are complete, but AHCCCS is operating in an optional use period that allows providers to submit their Legacy Identifier number (any identifier previously used to identify a health care provider prior to NPI), their NPI number (that is known to the AHCCCS system) or both.

Dual Use

AHCCCS began to accept NPIs on transactions as of 1/1/2007. If the NPI is sent on a transaction, only the NPI is used to process the transaction even though a Legacy Identifier may be present on the transaction. For example, AHCCCS will not attempt to process a transaction using the Legacy Identifier if the NPI is present on the transaction but not on file with AHCCCS. If the NPI has not been registered/enrolled by AHCCCS, then the transaction will fail.

Atypical service providers (those providers who do not provide traditional health care services such as non-emergency transportation) are not eligible for an NPI and should continue to use their existing Legacy Identifier.

AHCCCS will continue to accept submission of both the NPI and/or other legacy identifiers until a future date*.

Group Health Care Service Providers

Group Health Care Providers are entities composed of one or more individuals generally created to provide coverage of patients' needs in terms of office hours, professional backup and support or range of services resulting in specific billing or payment arrangements.

In the past, Group Billers could not submit their identifier in electronic claim submissions. With the advent of NPI usage, AHCCCS can now accept the Group NPI on electronic claim submissions (as is already the case with paper claim submissions).

The Billing Provider's NPI is the NPI sent in the 2010AA (Billing Provider Name) loop of the 837 Claim Transactions. The claim adjudication system no longer attempts to establish a relationship between the biller's tax identification number and the service provider's identification number.

***** Monitor AHCCCS' web page (http://www.azahcccs.gov/hipaa/Documents/PDFs/NPIDocuments/) for the latest updates regarding the NPI Contingency Plan.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	BPR	BPR01	Transaction Handling Code	This code designates whether and how the money and remittance information will be processed	I	Remittance Information Only
N/A	BPR	BPR02	Total Actual Provider Amount	The total payment for this batch or transaction		The Total Payment Amount on the 835 Transaction This is the amount of the weekly check or electronic transfer to the billing provider from an AHCCCS funding source (Acute, LTC, or KidsCare). The AHCCCS translator verifies that it balances to sums of 835 Transaction payment totals at service provider, claim and service line levels. When the Billing Provider that receives the transaction (REF02 within the transaction header) and the Rendering Provider (Loop 2100, Element NM109) are the same, balancing is for a single 835 provider/receiver. If the Total Payment Amount on an 835 Transaction is negative due to a preponderance of payment recoveries, zero appears in this element. Positive and negative amounts are available at the institutional claim or professional/dental service line level.
N/A	BPR	BPR10	Originating Company Identifier	A unique identifier designating the company originating the transaction	1866004791	The AHCCCS Federal Tax ID Number preceded by the number “1”. For the organization originating the transaction. Used when BPR04 is “ACH” or “FWT”.
N/A	TRN	TRN03	Originating Company Identifier	A unique identifier designating the company originating the transaction	1866004791	The AHCCCS Federal Tax ID Number preceded by the number “1”. For the organization originating the transaction.
N/A	TRN	TRN04	Reference Identification	Originating company supplemental code	AHCCCS	AHCCCS will appear in the payment NACHA CCD+ ACH format, addenda record type 7, Payment-Related Information data element.
1000A	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000A	N1	N102	Payer Name	Name identifying the organization remitting the payment	AHCCCS	Name of organization making the payment.
1000A	N3	N301	Payer Address Line	Address line for the payer's address		AHCCCS Street Address Line 1 (“701 E. Jefferson”)
1000A	N4	N401	Payer City Name	The city name of the payer's address		AHCCCS City (“Phoenix”)
1000A	N4	N402	Payer State Code	State postal code of the payer's address		AHCCCS State Code (“AZ”)
1000A	N4	N403	Payer Postal Zone or ZIP Code	The postal zone code of the payer's address		AHCCCS Zip Code (“85034”)
1000A	PER	PER01	Contact Function Code	Code identifying the major duty or responsibility of the person or group named.	CX	Payers Claim Office
1000A	PER	PER02	Payer Contact Name	Free-form name	IN STATE	
1000A	PER	PER03	Communication Number Qualifier	Code identifying the type of communication number.	TE	Telephone
1000A	PER	PER04	Payer Contact Communication Number	Complete communications number including country or area code when applicable.	6024177670	The contact local telephone number for AHCCCS
1000A	PER	PER05	Communication Number Qualifier	Code identifying the type of communication number.	TE	Telephone
1000A	PER	PER06	Payer Contact Communication Number	Complete communications number including country or area code when applicable.	8007947670	The contact 800 telephone number for AHCCCS
1000B	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PE	Payee
1000B	N1	N102	Information Receiver Last or Organization Name	The name of the organization or last name of the individual that expects to receive information or is receiving information		Receiver Name

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000B	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI XX	The payee's Federal Taxpayer's ID Number National Provider ID
1000B	N1	N104	Payee Identifier	Number identifying the organization receiving the payment		After 05/22/2007, the National Provider ID will appear in this field. Prior to that date, this will be the Payee's Tax ID Number
1000B	N3	N301	Payee Address Line	The payee's address line		Payee's Street Address Line 1
1000B	N3	N302	Payee Address Line	The payee's address line		Payee's Street Address Line 2
1000B	N4	N401	Payee City Name	The City Name of the payee's address		Payee's City
1000B	N4	N402	Payee State Code	The State Postal Code of the payee's address		Payee's State
1000B	N4	N403	Payee Postal Zone or ZIP Code	The Zip Code of the payee's address		Payee's Zip Code
1000B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	TJ	Federal Taxpayer ID Number Qualifier
1000B	REF	REF02	Additional Payee Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		Federal Taxpayer ID Number of the provider. Always present. The Billing Provider can be the same as or different from the Institutional Claim Facility or the Professional/Dental Rendering Provider
2000	TS3	TS301	Provider Identifier	Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider		Atypical Service Providers The AHCCCS ID and Location Code of the provider. Health Care Service Providers The National Provider Identifier (NPI).
2000	TS3	TS302	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format	99	AHCCCS uses Location Code "99" (Other Unlisted Facility) to populate this required field. Location Codes that more truly indicate where the service was performed appear at the claim level.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000	TS3	TS303	Fiscal Period Date	Last day of provider's fiscal year		December 31 of the current year in CCYY1231 format. All claims reported for a provider will always fall within the same fiscal period.
2000	TS3	TS304	Total Claim Count	Total number of claims in this 2000 Loop		The number of paid and denied claims reported for the service provider in Element TS301. Pended claims and claims not yet processed are not included in the 835 Transaction.
2000	TS3	TS305	Total Claim Charge Amount	The sum of all charges included within this 2000 Loop		The total charges for all paid and denied claims reported for the service provider in Element TS301.
2100	CLP	CLP02	Claim Status Code	Code specifying the status of a claim submitted by the provider to the payor for processing	1 2 3 4 22	Processed as Primary (Original Paid and Replacement Claims) Processed as Secondary Processed as Tertiary Denied Reversal of Previous Payment (Void Claims and the void component of Replacement Claims) These are the Claim Status Code values used by AHCCCS on 835 Transactions. “Processed as Primary” indicates a normal payment. For claim reversals, two claims appear, one to void the original (CLP02 = “22”) and the other to create a new replacement claim (CLP02 = “1”).
2100	CLP	CLP03	Total Claim Charge Amount	The sum of all charges included within this claim		The Total Charged Amount for the claim. This amount includes Share of Cost payments by the patient and amounts paid by other carriers prior to AHCCCS.
2100	CLP	CLP04	Claim Payment Amount	Net provider reimbursement amount for this claim (includes all payments to the provider)		The amount AHCCCS would have paid prior to any discounts or interest.
2100	CLP	CLP05	Patient Responsibility Amount	The amount determined to be the patient's responsibility for payment		The Share of Cost Amount paid by the recipient. If a Share of Cost Amount is paid by a patient, it is included in the provider’s Charged Amount and shown on the claim level CAS Segment.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	CLP	CLP06	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	MC	Medicaid
2100	CLP	CLP07	Payer Claim Control Number	A number assigned by the payer to identify a claim The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN)	00 - 99	The 14-character Claim Reference Number (CRN) assigned by AHCCCS. At the claim level, the last two digits of the CRN are zeros.
2100	CLP	CLP08	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format		For Professional and Dental Claims, CLP08 is the Place of Service. Since PMMIS maintains Place of Service at the line rather than the claim level, CLP08 is the Place of Service from the initial line. For Institutional Claims, CLP08 consists of the first and second characters of the Type Bill Code.
2100	CLP	CLP09	Claim Frequency Code	Code specifying the frequency of the claim This is the third position of the Uniform Billing Claim Form Bill Type		CLP09 Claim Frequency Code values of “7” (Replacement) and “8” (Void) indicate claims that perform these functions. All other valid Claim Frequency values are for original claims.
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	QC	Patient
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100	NM1	NM103	Patient Last Name	The last name of the individual to whom the services were provided		The patient’s Last Name as submitted on the claim.
2100	NM1	NM104	Patient First Name	The first name of the individual to whom the services were provided		The patient’s First Name as submitted on the claim.
2100	NM1	NM105	Patient Middle Name	The middle name of the individual to whom the services were provided		If present, the patient’s Middle Name or Middle Initial as submitted on the claim.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	MR	Medicaid Recipient Identification Number
2100	NM1	NM109	Patient Identifier	Patient identification code		The recipient's nine-character AHCCCS ID.
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	74	Corrected Insured
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100	NM1	NM103	Corrected Patient or Insured Last Name	Corrected last name of the patient or insured		The recipient's Last Name as known to AHCCCS.
2100	NM1	NM104	Corrected Patient or Insured First Name	Corrected first name of the patient or insured		The recipient's First Name as known to AHCCCS.
2100	NM1	NM105	Corrected Patient or Insured Middle Name	Corrected middle name of the patient or insured		If present, the recipient's Middle Initial as known to AHCCCS.
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	82	Rendering Provider
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100	NM1	NM103	Rendering Provider Last or Organization Name	The last name or organization of the provider who performed the service		The full name of the service provider. This is how the Provider Name appears in PMMIS.
2100	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	XX	National Provider ID Qualifier
2100	NM1	NM109	Rendering Provider Identifier	The identifier assigned by the payer to the provider who performed the service		National Provider ID
2100	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number AHCCCS uses this REF Segment to show the AHCCCS CRN of a claim being replaced or voided.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	REF	REF02	Other Claim Related Identifier	Code identifying other claim related reference numbers		The 14 character Claim Reference Number (CRN) of the claim being replaced or voided when the Claim Frequency Code (CLP09) has a value of “7” (Replacement) or “8” (Void).
2100	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	I D8 AU F5	Interest (an additional amount paid by AHCCCS to the provider due to late claim payment) Discount Amount (a reduction in the amount paid by AHCCCS to the provider due to a prompt pay discount in the provider’s contract) Coverage Amount (the AHCCCS Allowed Amount) Patient Amount Paid (a Share of Cost Amount) An Allowed Amount is present for every claim. Other amounts are reported on separate AMT Segments when they are present. Amounts in this segment are independent of amounts in CAS Segments and are not referenced for internal balancing. They do, however, contribute to differences between Charged and Paid Amount reported in the CAS Segment. When this happens, the same Amount appears in both places.
2100	AMT	AMT02	Claim Supplemental Information Amount	Amount of supplemental information values associated with the claim		The positive or negative dollar amount described by the qualifier in AMT01.